MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ______

Name of Physician/and their specialty ______________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury ______
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - chlorhexidine (CHX)
   - metals (nickel, gold, silver, ____________)
   - latex
   - nuts ______
   - fruit ______
   - other ______
3. heart problems, or cardiac stent within the last six months ___
4. history of infective endocarditis ______
5. artificial heart valve, repaired heart defect (PFO) ______
6. pacemaker or implantable defibrillator ______
7. orthopedic implant (joint replacement) ______
8. rheumatic or scarlet fever ______
9. high or low blood pressure ______
10. a stroke (taking blood thinners) ______
11. anemia or other blood disorder ______
12. prolonged bleeding due to a slight cut (INR > 3.5) ______
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___
14. chronic ear infections, tuberculosis, measles, chicken pox ___
15. asthma ______
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ______
18. liver disease ______
19. jaundice ______
20. thyroid, parathyroid disease, or calcium deficiency ______
21. hormone deficiency ______
22. high cholesterol or taking statin drugs ______
23. diabetes (HbA1c = _______) ______
24. stomach or duodenal ulcer ______
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ______

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___
27. arthritis ______
28. autoimmune disease ______ (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ______
30. contact lenses ______
31. head or neck injuries ______
32. epilepsy, convulsions (seizures) ______
33. neurologic disorders (ADD/ADHD, prion disease) ______
34. viral infections and cold sores ______
35. any lumps or swelling in the mouth ______
36. hives, skin rash, hay fever ______
37. STI/STD/HPV ______
38. hepatitis (type ____) ______
39. HIV/AIDS ______
40. tumor, abnormal growth ______
41. radiation therapy ______
42. chemotherapy, immunosuppressive medication ______
43. emotional difficulties ______
44. psychiatric treatment ______
45. antidepressant medication ______
46. alcohol/recreational drug use ______

ARE YOU:

47. presently being treated for any other illness ______
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______
49. taking medication for weight management ______
50. taking dietary supplements ______
51. often exhausted or fatigued ______
52. experiencing frequent headaches ______
53. a smoker, smoked previously or use smokeless tobacco ___
54. considered a touchy/sensitive person ______
55. often unhappy or depressed ______
56. taking birth control pills ______
57. currently pregnant ______
58. diagnosed with a prostate disorder ______

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

ASA ______ (1-6)

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DENTAL HISTORY

Name________________________________ Nickname_______________________________ Age__________
Referred by____________________________How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist ________________________________How long have you been a patient?___________Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]______________ ☐ ☐
2. Have you had an unfavorable dental experience?______________ ☐ ☐
3. Have you ever had complications from past dental treatment?______________ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?______________ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?______________ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?______________ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ______________ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______________ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ______________ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ______________ ☐ ☐
11. Have you ever experienced gum recession? ______________ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______________ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ______________ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?______________ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______________ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______________ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?______________ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ______________ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?______________ ☐ ☐
20. Do you frequently get food caught between any teeth?______________ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______________ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together?______________ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______________ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?______________ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ______________ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ______________ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?______________ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______________ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore?______________ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ______________ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?______________ ☐ ☐
34. Have you ever whitened (bleached) your teeth? ______________ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______________ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ______________ ☐ ☐

Patient's Signature ____ Date ____________________
Doctor's Signature ____ Date ____________________

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Acknowledgement: Receipt of

Notice of Privacy Practices

I have reviewed and been offered a copy of the *Notice of Privacy Practices* from:

Dr. Stone's Office — October 12, 2020

Practice Name — Effective Date

Patient Acknowledgement

Patient Name (please print)

Patient Signature — Effective Date

Representative Signature (if patient is unable to sign) — Effective Date

Representative Name and relationship to the patient (please print)

PATIENT INFORMATION

Name (Nickname): ___________________________
Social Security #: ___________________________
Mail Address: ___________________________
____
Responsible Party: ___________________________
Relationship: ___________________________

Birthdate: ___________________________
Home Phone: ___________________________
Cell Phone: ___________________________
Preferred Contact: Call ________ Text________
Emergency Contact: ___________________________
Phone: ___________________________

How did you hear about us? (check all that apply):

- Postcard
- Newspaper
- Internet
- Location
- Friend/Family (name) _______________

Would you like for us to be able to share your dental information with anyone else? (example: spouse or parent)

____
Name and relationship to patient

INSURANCE INFORMATION

Will you be using dental insurance: Yes _____ No _____
***If yes, please present your card to an office team member.**

PATIENT AUTHORIZATION

I understand:

- *My dental insurance carrier may pay less than the actual bill for service*
- *I am responsible for payment of all services rendered on behalf of myself & my dependents*
- *I can receive a personal copy of HIPPA upon my request*
- *I can withdraw my consent at any time*

I authorize Dr. Stone's Office to:

- *Release any diagnostic, treatment, or examination records to third party payors and/or health practitioners*
- *Submit insurance claims & accept payment from my insurance company*
- *Use my phone number to call &/or text regarding appointments, treatment, insurance &/or my account*
- *Share unidentifiable photos of treatment*
- *Allow licensed office providers to administer local anesthetic, if needed*

I have read & understand the above.

____ _________________________
Signature *Date*